907 KAR 1:155E
Material Incorporated by Reference

Supports for Community Living Cost Report
December 1999 edition

Instructions for SCL Cost Reporting
December 1999 edition

Financial Information Listing
March 2000 edition

MAP-95 Request for Equipment Form
September 2002 edition

North Carolina Needs Assessment Profile NC-SNAP
2000 edition
(not displayed due to copyright)

North Carolina Needs Assessment Profile NC-SNAP
Instructor's Manual 1999 edition
(not displayed due to copyright)

Filed: January 17, 2003

CLEAN

INSTRUCTIONS FOR SCL COST REPORTING

These instructions are intended to guide vendors in preparing the annual cost report. In completing the schedules, the period beginning and period ending, the provider name, provider number, and addresses must be indicated on the cover page. Providers shall submit a cost report prepared on the accrual basis of accounting and otherwise consistent with generally accepted accounting principles.

SCHEDULE A – UNIT COST INFORMATION

The column "Line #" is available for the preparer to manually number each line of information consecutively for as many lines of information as shall be necessary.

Column #1 – Unit Code – This column should contain the provider's unique alpha or numeric identification for each service or support activity cost center.

Column #2 – Cost Center – This column should contain the provider's designated title for each service or support activity center.

Columns #3 – 8 – Should contain the expenses of the following specific general ledger account titles which shall have been identified with the service or support activity cost centers.

Column #3 - Personnel Costs includes Personnel Services as listed below:

1. Salaries,
2. Wages,
3. Flexible Benefits – Child Care,
4. Flexible Benefits – Medical Reimbursement,
5. Flexible Benefits – Health Insurance,
6. Flexible Benefits – Dental Insurance,
7. Performance Incentive,
8. Recognition Award; and
9. Fringe Benefits.

Column #4 – Facility Costs which includes Facility and Site Expenses (as indicated below), Repair and Maintenance Expenses related to the building, Interest Expense related to the building, and Depreciation and Amortization Expenses related to the building.

Facility and Site Expenses include:

1. Telephone,
2. General Liability Insurance and Fire Insurance,
3. Moving Expense related to Facilities,
4. Building Usage Expense,
5. Building Rental – External,
6. Utilities,
7. Program Off-Site Space Cost; and
8. Maintenance and Janitorial Supplies.

Column #5 – Travel and Transportation which includes the following expenses:

1. Travel Outside the Region,
2. Travel Outside the State,
3. Travel Within the Region,
4. Board Member and Volunteer Reimbursement,
5. Gas and Oil,
6. Client Transportation,
7. Vehicle License Expense,
8. Vehicle Insurance Expense,
9. Vehicle Rental,
10. Vehicle Rental – External
11. Miscellaneous

Also included in this column would be Repair and Maintenance Expenses related to the vehicles, Depreciation and Amortization related to the vehicles, and Interest Expense related to the vehicles.

Column #6 – Subcontracts which includes the expenses for subcontracted services as described below:

1. Payments to Subcontractors – Grants
2. Payments to Subcontractors – DMH/MR

Column #7 – Other Operating are those expenses not accounted for in columns 3 through 6 and includes expenses related to General Operating Expenditures, Professional Services, Contracted Services, Program Supplies and Expenses, Repair and Maintenance, Interest Expense, and Depreciation and Amortization.

The General Operating Expenditures include the following:

1. Layout, design, and typesetting,

2. Office Supplies,
3. Advertising (Letters, Newspapers, Electronic Media, etc.),
4. Recruiting,
5. Subscription and Membership Dues,
6. Licenses,
7. Delivery Expense,
8. Books,
9. Advertising – Special,
10. Office Equipment – Usage,
11. Printing and Promotional,
12. Postage,
13. Printing – Forms,
14. Professional Meetings,
15. Training Expenses,
16. Out of State Training Expenses,
17. Cash Over/Short,
18. Penalty Charges,
19. Bank Service Charges,
20. Loss Due to Theft,
21. Administrative Charges,
22. Annual Meeting,
23. Annual Report; and
24. Miscellaneous.

Professional Services expenses include the following:

1. Legal Expenses,
2. Data Processing,
3. Audit and Evaluation,
4. Miscellaneous Public Relations; and
5. Security Services.

Contracted Services expenses include the following:

1. Program Professional – Internal,
2. Program Professional – Therapists, Psychologists, etc.
3. Medical Psychiatrists,
4. Professional Consultants,
5. Respite Care Service,

6. Consultation,
7. Services from Personnel Agencies; and,
8. Miscellaneous.

Program Supplies and Expenses include the following:

1. Fundraising – Usage of Funds,
2. Dietary Supplies,
3. Drugs,
4. Laboratory Expenses,
5. Medical Supplies,
6. Pharmaceutical and Supplies,
7. Educational and Craft,
8. Recreational,
9. Food – Daily Meals,
10. Laundry Expenses,
11. Client Personal Supplies,
12. Client SSI Expenses; and
13. Miscellaneous.

Repair and Maintenance includes expenses related to equipment and other. The Interest Expense is related to other items not included in other categories within the cost report. Depreciation and Amortization includes expenses related to other items not included in other categories within the cost report.

Column #8 – In-Kind Expenses includes services from volunteers and other donated goods and services. These goods and services should be valued at the cost you would reasonably expect to incur had these items been purchased, rather than donated. This valuation should be documented in provider records.

Column #9 – Subtotal – Add the information from column #3 through column #8 for each cost center and put the sum in this column.

Column #10 – Reclassification and Allocations – The total of all "Local" reclassifications or allocation for each of the cost centers which have been explained in Schedule A-1 should be entered into this column. Indicate decreases or subtractions in brackets.

Column #11 – Total – Add the information from column #9 to the information from column #10 for each cost center and enter the sum into this column.

Column #12 – Line # Reference – Enter in this column, the line number from Schedule B into which the cost of each individual cost center should be

forwarded. **Do not** reclassify all similar cost centers to a single line prior to forwarding the cost information on to Schedule B.

SCHEDULE A-1 – LOCAL RECLASSIFICATION AND ALLOCATIONS

This schedule shall be to provide for the adjustments which may be necessary to properly allocate the expenses which have been accumulated in local support activity cost centers to those service activity centers which they benefit. This schedule also provides for the allocation of service activity costs which must be separate to identify the cost of providing each service independently.

"Line #" – In this column, the preparer must manually number each line of information consecutively for as many lines of information as necessary.

Column #1 – Cost Center/Explanation – In this column the preparer must enter the title of the cost centers which are affected by the adjustment and then, immediately below the titles, sufficiently explain the purpose of the adjustment and the basis used for any allocation of cost.

Column #2 – WP Ref – This column is used for the preparer to manually cross reference (index) work papers which he/she developed to explain all adjustments.

Columns #3 and 4 – Schedule A Line and Column – These columns refer to the line and column numbers of Schedule A where the adjustment is forwarded.

Columns #5 and 6 – Increase/Decrease – The amount of the adjustment relating to each cost center must be entered here.

SCHEDULE B – TOTAL ALLOWABLE EXPENSES

This schedule is used to summarize the cost information presented in Schedule A, to apportion organization-wide administrative and clinical support costs, and to further adjust the provider's expenses to recognize non-reimbursable items of cost.

Column #1 – Total Costs – Enter in this column the summary total of costs from Schedule A, Column 11, for each cost center as indicated in Schedule A, column 12. Example: The total cost of all cost centers from Schedule A, column 11 which also have line #20 indicated in Schedule A, Column 12, are to be added together and their sum placed on Schedule B, Line 20, column 1.

Column #2 – Adjustments – Enter in this column the total of all adjustments to cost from Schedule C, Column 8 for each cost center.

Column #3 – Total Cost after Adjustment – Subtract column #1 from column #2 for each line item, and enter the result in the corresponding line in column 3. This column will then report allowable cost after adjustment has been made.

Column #4 – Administrative Allocation – This column provides for the allocation of total allowable indirect organization wide administrative costs as determined by adding the information contained on Schedule B, line 1, column 1 to Schedule B, line 1, column 2. Place this sum in brackets on Schedule B, line 1, Column #3. The allocation is accomplished by dividing the total allowable indirect organization wide administrative costs (Schedule B, line 1, column 4) by the total of Schedule B, column 3, less the information on lines 1,2 and on any line(s) designated as "pass through". This will produce a "factor" which shall be entered in the space at the top of column #4 and then be multiplied against each amount listed in Schedule B, column 3, except for those lines omitted above, with the product of each of those multiplications being placed on the corresponding line in Schedule B, column 4, in order that the total of column 4 will equal zero (0).

Column #5 – Clinical Support Allocation – This column provides for the allocation of total allowable organization wide clinical support costs as determined by adding the information contained on Schedule B, Line 2, Column 1 with that on Schedule B, Line 2, Column 2, and placing its sum in brackets on Schedule B, Line 2, Column 5. The allocation is accomplished by dividing the total allowable clinical support costs (Schedule B, Line 2, Column 5) by the total of Schedule B, Column 3, less the information on lines 1,2 and on any line(s) designated as "pass through". This will produce a "factor" which shall be entered in the space at the top of column #5 and then be multiplied against each amount listed in Schedule B, column 3, except for those lines omitted above, with the product of each of those multiplications being placed on the corresponding line in Schedule B, column 5, in order that the total of column 5 will equal zero (0).

Column #6 – Total Allowable Expenses – In this column, the information from columns #3, #4 and #5 are added together and the sum entered here.

SCHEDULE C – ADJUSTMENTS TO COST

This schedule is used to recognize those items of cost which are not reimbursable by Medicaid and summarize the costs by service cost center for subsequent adjustment on Schedule B.

The column descriptions indicate the more common activities which require adjustment. Types of items to be entered on Schedule C include:

1. Those needed to adjust cost to reflect actual expenses incurred,
2. Those items which constitute recovery of expense,

3. Those items specifically addressed by contract(s); and
4. Those items required to comply with applicable federal and state laws or regulations.

Column #1 – Out of State Travel – Enter in this column those expenses which shall be considered to be non-reimbursable as defined:

> Travel and associated costs outside the Commonwealth of Kentucky for purposes of conventions, meetings, assemblies, conferences or any related activities are not allowable costs. However, costs (excluding transportation costs) for training or educational purposes outside the Commonwealth of Kentucky shall be allowable costs. Even though the meetings per se are not educational, costs (excluding transportation) shall be allowable if educational or training components are included.

Column #2 – Bad Debts – Enter in this column those expenses which are considered to be non-reimbursable as defined in the Supports for Community Living Payment Rate Determination Manual, Section 206.

Column #3 – Interest – Enter in this column those expenses which are considered non-reimbursable based on Section 205 of the Supports for Community Living Payment Rate Determination Manual.

Column #4 – Management Vehicles – Enter in this column those expenses which are considered non-reimbursable based on Section 204 of the Supports for Community Living Payment Rate Determination Manual.

Column #5 – Program Income – Enter in this column those revenues which are to be offset against expenses based on Section 215 of the Supports for Community Living Payment Rate Determination Manual.

Column #6 – Restricted Donations – Enter in this column those grants or gifts which have been donor restricted as described in Section 209 of the Supports for Community Living Payment Rate Determination Manual.

Column #7 – Other Non-Allowable – Self explanatory.

Column #8 – Total – Add the information from Column #1 through Column #7 for each cost center. Forward this sum to Schedule B, Column 2, for each respective cost center

SCHEDULE D – TOTAL UNITS OF SERVICE

This schedule serves as the initial entry point for the units of service information. With the exception of those services provided through sub-contractors, the units of service placed on Schedule D must reflect **the total number of services**

provided (both Medicaid and non-Medicaid). In the case of sub-contractors, only the number of services purchased is placed on Schedule D.

Column #1 – CMHC Units – Enter in this column those units of service, which were provided under Medicaid's Community Mental Health Center (CMHC) Program.

Column #2 – SCL Units – Enter in this column those units of service provided under Medicaid's Supports for Community Living (SCL) Program.

Column #3 – Other Payors – Enter in this column those units of service not included in columns 2 and 3 that were provided by your organization.

Column #4 – Total – Add the information from Columns #1, #2, and #3 for each fee for service cost center.

SCHEDULE E – COST PER SERVICE

Schedule E derives the cost per unit of service by dividing total cost by total units to arrive at the average cost per unit of service delivered.

Column 1 – Enter the allowable expenses for each cost center from Schedule B, Column 6, for each corresponding cost center.

Column 2 – Enter the total units of service from Schedule D, Column 4, from each corresponding cost center.

Column 3 – Divide Column 1 by Column 2 for each corresponding cost center. The resulting amount is the average cost per unit of service for that cost center.

SCHEDULE Z – STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS

Schedule Z, Section A must be completed by all providers to show whether any of the costs to be reimbursed Medicaid include any transactions for services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control.

Section B must be completed by all providers to show the total compensation paid for the period to corporate officers. Compensation is defined as the total benefit received (or receivable) for the services rendered to the institution. It must include salary paid for managerial, administrative, professional, and other services. Amounts paid by the agency for the personal benefit of corporate officers must be included. The cost of the assets and services which corporate officers receive from their agency and deferred compensation must also be

SUPPORTS FOR COMMUNITY LIVING
SCHEDULE A

PROVIDER NAME: ______________________________

PROVIDER NUMBER: ______________________________

FYE: ______________________

UNIT COST INFORMATION

LN #	UNIT CODE (1)	COST CENTERS (2)	PERSONNEL (3)	FACILITY COSTS (4)	TRAVEL & TRANS. (5)	SUB-CONTRACTS (6)	OTHER OPERATING (7)	IN-KIND (8)	SUBTOTAL (9)	RECLASS & ALLOC. INC/(DEC) (10)	TOTAL (11)	SCH B LN # REF (12)

SUPPORTS FOR COMMUNITY LIVING
SCHEDULE A-1

PROVIDER NAME: ______________________

PROVIDER NUMBER: ______________________

FYE: ______________________

LOCAL RECLASSIFICATION AND ALLOCATIONS

LN #	COST CENTERS (1)	W/P REF (2)	SCHEDULE A LINE (3)	SCHEDULE A COL. (4)	INCREASE (5)	(DECREASE) (6)

SUPPORTS FOR COMMUNITY LIVING
SCHEDULE B

PROVIDER NAME: _____ **FYE:** _____

PROVIDER NUMBER: _____

TOTAL ALLOWABLE EXPENSES

LN #	COST CENTERS	TOTAL COSTS (1)	ADJUSTMENTS (SCHEDULE C, COL 8) (2)	TOTAL ADJUSTED COST (3)	ADMINISTRATIVE ALLOCATIONS Factor _____ (4)	CLINICAL SUPPORT ALLOCATION Factor_____ (5)	TOTAL ALLOWABLE EXPENSES (6)
1	Organization-Wide Administration						
2	Organization-Wide Clinical Support						
	SCL						
3	Support Coordination						
4	Family Home						
5	Staffed Residence						
6	Group Home						
7	Community Habilitation						
8	Community Living Supports						
9	Respite						
10	Speech Therapy						
11	Occupational Therapy						
12	Physical Therapy						
13	Behavior Support						
14	Psychological Services						
15	Supported Employment						
16	Wellness Monitoring						
17	Specialized Services and Supplies						
18	PERS						
	Non-Reimbursable Cost Centers						
19							
20							
21							
22							
23							
24	Grand Totals						

SUPPORTS FOR COMMUNITY LIVING
SCHEDULE C

PROVIDER NAME: _____ **FYE:** _____

PROVIDER NUMBER: _____

ADJUSTMENTS TO COST

LN #	COST CENTERS	OUT -OF STATE TRAVEL (1)	BAD DEBTS (2)	INTEREST EXPENSE (3)	MANAGEMENT VEHICLES (4)	PROGRAM INCOME (5)	RESTRICTED DONATIONS (6)	OTHER NONALLOWABLE (7)	TOTAL (8)
1	Organization-Wide Administration								
2	Organization-Wide Clinical Support								
	SCL								
3	Support Coordination								
4	Family Home								
5	Staffed Residence								
6	Group Home								
7	Community Habilitation								
8	Community Living Supports								
9	Respite								
10	Speech Therapy								
11	Occupational Therapy								
12	Physical Therapy								
13	Behavior Support								
14	Psychological Services								
15	Supported Employment								
16	Wellness Monitoring								
17	Specialized Services and Supplies								
18	PERS								
	Non-Reimbursable Cost Centers								
19									
20									
21									
22									
23									
24	Grand Totals								

SCHEDULE D
TOTAL UNITS OF SERVICE

PROVIDER NAME_____
PROVIDER #_____
PERIOD _____

LN#	Services	(1) CMHC Units	(2) SCL Units	(3) Other Payors	(4) Total Units
1	**SCL SERVICES**				
2	Support Coordination				
3	Community Habilitation				
4	Supported Employment				
5	Group Homes				
6	Staffed Residences				
7	Family Homes				
8	Community Living Supports				
9	Behavior Supports				
10	Psychological Services				
11	Occupational Therapy				
12	Physical Therapy				
13	Speech Therapy				
14	Respite				
15	Wellness Monitoring				
16	Personal Emergency Response System (PERS)				
17	Specialized Services and Supplies				
18					
19					
20					
21					
22					
23	**CMHC SERVICES**				
24	Intensive InHome				
25	Therapeutic Rehabilitation				
26	Outpatient Individual Therapy				
27	Outpatient Psychiatrist Therapy				
28	Outpatient Group Therapy				
29	Personal Care Remotivation				
30	Hospital Psychiatrist				
31	Hospital Other Professional				
32					

SUPPORTS FOR COMMUNITY LIVING
SCHEDULE E

PROVIDER NAME: _____

PROVIDER NUMBER: _____

FYE: _____

SCL COST PER SERVICE

LN #	COST CENTERS	TOTAL ALLOWABLE EXPENSES (1)	TOTAL UNITS OF SERVICE (2)	COST PER SERVICE (4)
3	Support Coordination			
4	Family Home			
5	Staffed Residence			
6	Group Home			
7	Community Habilitation			
8	Community Living Supports			
9	Respite			
10	Speech Therapy			
11	Occupational Therapy			
12	Physical Therapy			
13	Behavior Support			
14	Psychological Services			
15	Supported Employment			
16	Wellness Monitoring			
17	Specialized Services and Supplies			
18	PERS			
	Non-Reimbursable Cost Centers			
19				
20				
21				
22				
23				
24	Grand Totals			

SUPPORTS FOR COMMUNITY LIVING
CERTIFICATION SCHEDULE Z

PROVIDER NAME: _____

PROVIDER NUMBER: _____

FYE: _____

A. STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS

1. In the amounts to be reimbursed by the Cabinet, as reported on Schedule B, are any costs included which are a result of transactions with related organizations?

☐ YES ☐ NO

2.

Schedule	Line Number	Item	Amount

3. Name and percent of direct or indirect ownership of the related organization.

NAME OF OWNER	NAME OF RELATED ORGANIZATION	PERCENT

B. STATEMENT OF COMPENSATION PAID TO EXECUTIVE DIRECTORS, ADMINISTRATORS, OR ASSISTANT ADMINISTRATORS

NAME	TITLE	PERCENT OF CUSTOMARY WORK WEEK DEVOTED TO BUSINESS	PERCENT OF PERIOD EMPLOYED	TOTAL COMPENSATION FOR THE PERIOD

C. CERTIFICATION BY OFFICER OR DIRECTOR OF THE PROVIDER

INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE OR IMPRISONMENT OR BOTH UNDER FEDERAL LAW.

I, HEREBY CERTIFY, that I have read the above statement and that I have examined the accompanying Annual Cost Report prepared by _____, for the period beginning _____ and ending _____, and that to the best of my knowledge and belief it is a true, correct and complete report prepared from the books and records of the provider in accordance with applicable instructions except as noted.

_____

Signed Officer/Director Title Date

FINANCIAL INFORMATION LISTING

Copy of Long-Term Note(s)*, i.e. notes payable
Loan Amortization Schedule* changes in interest rate if variable
Copy of Contracts*
Financial Statements

Adjusted Trial Balance**
Work papers concerning adjustment to Trial Balance
Lead Schedules (schedule showing location of account on cost report – may be shown on Trial Balance)**

Work Papers supporting Cost Report Adjustments and Reclassifications**

Patient Census/or visits, units of stay, etc.**

Depreciation Schedule (complete schedule not just the additions and deletions)**

Disclosure Statement (enclosed)**

Accounts payable listing**

* To be submitted one time unless conditions change
** Cost Report will be rejected as "not received" if these items are not submitted. This will result in the facility being put in escrow until items are received.

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

REQUEST FOR EQUIPMENT FORM

RECIPIENT'S NAME _____ MAID # _____ BIRTHDATE _____
Mo Day Yr

List Other Insurance Coverage _____

Estimated Time Needed # Months_____ Indefinitely _____ Permanently _____

Specific Equipment Item Requested: Please include Medicare codes for parts to items such as Braces, Prostheses, and Wheelchairs (if applicable). Otherwise, group parts together under Code E1399 or appropriate miscellaneous code for braces/prostheses.

PURCHASES:

ITEM	CODE	MANUFACTURER'S SUGGESTED LIST PRICE (IC ITEMS ONLY)	AGENCY'S ACQUISITION COST (ALL ITEMS)

Trade Name/Model Number of Equipment item (if applicable) _____

_____

Manufacturer's Name _____

RENTAL:

If Rental is Requested, Please Specify Amount $_____

Supplier of Equipment _____

Address _____

Date of Delivery if Equipment Item is Already Place in Home – Date _____

Agency Name _____ Provider # _____

Authorized Signature _____ Date _____